STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE WOODS	2335 NORTH MADISON AVENUE ANDERSON, IN46011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	This visit was for the Investigation of Complaint IN00093520. Complaint IN00093520 - Substantiated. State residential findings related to the allegations are cited at R052, R214, and R349. Survey date: July 15, 2011 Facility number: 010409 Provider number: 010409 AIM number: N/A Survey team: DeAnn Mankell, R.N. Census bed type: Residential: 58 Total: 58 Census payor type: Medicaid: 24 Other: 34 Total: 58 Sample: 3 These state residential findings are cited in accordance with 410 IAC 16.2.5. Quality review 7/21/11 by Suzanne Williams, RN	R0000	Submission of the plan of correction does not constitute an admission to or agreement by Keystone Woods Assisted Living Community with the alleged facts found on this survey. Submission of this plan of correction is a matter of regulatory compliance	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R0052	(v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on record review, observation, and interview, the facility failed to ensure cognitively impaired residents, who were independently ambulatory, were free from neglect and supervised in a manner that ensured when they went outside of the facility onto the facility grounds unsupervised, they were able to re-enter the facility. This practice affected 2 of 3 residents in a sample of 3 with a dementia diagnosis who were locked out of the facility for 6 hours at night. (Residents A and B). Findings include: 1. On 7/15/11 at 10:20 A.M., during the entrance interview with the Administrator, she indicated there were no wandering residents in the facility. She indicated there were residents with dementia, but there were none who had attempted to leave the facility. She did indicate there were two residents, a husband and his wife (Residents A and B), who had exited the building and they were not able to return due to the doors being locked. She indicated they both had dementia and	R0052	R0052 WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The policy for when to lock the doors was changed on 07/11/2011 from 8pm to 10pm. This would allow for residents going outside on the front porch during daylight hours to do so without being locked out. A sign was posted on each of the doors directing persons to use the after-hours phone located to the side of each door, to notify staff to come and open the door on 07/11/2011. Both residents A & B had mental status questionnaires completed on 08/02/2011 to determine if they are appropriate to remain in an independent setting. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: The policy for when to lock the doors was changed on 07/11/2011 from 8pm to 10pm. A sign was posted on each of the doors directing persons to use the after-hours	08/05/2011

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	would leave the building at will and walk on the grounds or sit on the front porch. She said they were not monitored as they were independent and didn't need to be monitored. She said if they needed assistance, Resident A, the husband, would go up to the nurses and ask for help for himself or his wife. She said they had a pendent call button, but they didn't use it. She said Residents A and B had left the building and couldn't return one night as the doors were locked, but the facility had since left the doors unlocked until 10:00 P.M. She thought they had gone outside because it was still light out at 9:00 P.M. She further indicated the only way she knew what had happened was by watching the video from the camera at the front entrance. She indicated this camera was not able to be seen on the monitor in the nurses' station, but she was able to view it on another monitor that she could access. She said Resident A had pulled the gliders into the area between the two sets of front doors and the residents had attempted to sleep there. She said Resident A appeared to have a flip phone, which he attempted to use, but was unable to do so. She indicated he could be seen hitting the front door. She indicated there was a phone on the wall with instructions on the number to call at the nurses' station, but he didn't attempt to call the nurses' station.		phone to notify staff to come and open the door on 07/11/2011. All residents with a dementia diagnosis had mental status questionnaires completed on 08/02/2011 to determine if they are appropriate to remain in an independent setting. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES THE FACILITY WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The policy for when to lock the doors was changed on 07/11/2011 from 8pm to 10pm. A sign was posted on each of the doors directing persons to use the after-hours phone to notify staff to come and open the door on 07/11/2011. The pre-screening process will include the mental status questionnaire to determine if potential new residents with cognitive impairments are appropriate for an independent setting. The nursing staff were informed of the policy to change the time to lock the doors, and who is responsible to lock the doors, plus reminded of the policy revision to check the front entrance every 2 hours during the hours of 10p-6am on 07/11/2011. The nurses were reminded on 08/03/2011 of the policy change regarding what time to lock the doors and who is responsible to lock the doors, plus reminded of the policy revision to check the front entrance every 2 hours	

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	On 7/15/2011 at 11:00 A.M., the Administrator provided a copy of the incident report which was sent to the ISDH (Indiana State Department of Health) on 07/11/2011. The incident occurred on 07/10/2011 into 07/11/2011. The brief description of the incident indicated: "At 9PM on 07/10/11, (names of Residents A and B) walked out the front door to sit on the front porch glider. They were unaware of the front door being locked from the outside at 8PM. At 9:20PM (names of Residents A and B) attempted to come back into the building and discovered the front door was locked. (names of Residents A and B) are independent with nursing services (dressing, ambulation, toileting, feeding etc) but do have dementia. They could not figure out how to use the after hours phone located by the front door nor could they process a solution for notifying someone that they were locked out. (Name of Resident A) brought the front porch glider into the foyer area (This is an area between two sets of front doors which is enclosed) and they slept on the porch glider until 4AM. At 4AM, (Resident A) walked to the side of the building and knocked on (Name of Resident)'s apartment window. (Name of Resident) then called the police stating		during the hours of 10p-6am to ensure no resident is locked outside. The nursing staff will check all 3 entrance/exit doors every 2 hours during the hours of 10p-6am. The charge nurse is responsible for completing the census sheet every night at midnight and will ensure that all residents are accounted for during the nightly census check. HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE The Administrator, or designee, will review the surveillance video daily to ensure that staff are locking the doors at the designated time and to ensure that staff are conducting the 2 hour checks on the front entrance. The Administrator or designee will correct any discrepancy with that staff member with a progressive discipline. Upon 100% compliance over a 30-day consecutive time period, the observations will decrease to three (3) times a week. The Administrator will review the findings of the observations during the monthly Safety Committee Meeting and then at the quarterly QA meeting. The monitoring will continue until there is 100% compliance for 6	

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	someone was trying to break into her apartment. The police called the facility and notified the staff of the call. The staff went to investigate and discovered that (Residents A and B) were in the foyer area at 4:13 AM. (Names of Residents A and B) were not injured. (Names of Residents A and B) then went to their apartment." The immediate action taken was: "(Names of Residents A and B) were assessed for injury and none was noted. The DON was notified at 6AM on 07/11/2011. The Administrator was notified at 11AM on 07/11/2011. The Administrator began an investigation to determine the timeline of events. The investigation included review of surveillance tapes of the front door. The investigation was concluded at 7PM and noted the above description of the incident." The preventive measures taken were: "On 7/11/2011 the protocol for locking the front door was revised to lock the front doors at 10PM instead of 8PM. The (Name of Residents A and B) were placed on 2-hour checks from 10P-6A for whereabouts verification on 07/11/2011. A door bell is being installed at all entrance areas so that a person can ring the door bell to summon staff (an after hours phone is all ready located at each entrance with the nurse's (sic) station		consecutive months.	

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	number posted). A sign is posted on the front door stating the door is locked at 10PM and you can not get back in unless you call the nurse's station for any one exiting the front door." Resident A's clinical record was reviewed on 7/15/2011 at 10:55 A.M. Resident A's diagnoses included, but were not limited to, dementia. Resident A's undated "Elopement Risk Record" indicated "yes" was checked for cognitively impaired with poor decision-making skills, independent ambulation and wandering aimlessly. The form indicated ".... one YES placed the resident at risk. Proceed to interventions." There were no interventions in place according to this form. Resident A's nurse's notes lacked any notation of this incident or an assessment after the incident. Resident A had a guardian. Resident B's clinical record was reviewed on 7/15/2011 at 11:08 A.M. Resident B's diagnoses included, but were not limited to, dementia and confusion.			

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	Resident B's undated "Elopement Risk Record" indicated "yes" was checked for cognitively impaired with poor decision-making skills,pertinent diagnosis of dementia, independent ambulation and pain. The form indicated ".... one YES placed the resident at risk. Proceed to interventions." There were no interventions in place according to this form. Resident B's nurse's notes lacked any notation of this incident or an assessment after the incident. Resident B had a guardian. Residents A and B were interviewed on 7/15/2011 at 12:30 P.M. Resident B did not talk. Resident A indicated they had gone outside, but they couldn't get back in the building and he had pounded on the door and had kept pounding on the door. He said he had to stand as he had nothing to sit on and he got tired as it was a long time. Residents A and B were observed sitting outside the building on 7/15/2011 at 12:40 P.M. on the front porch with other residents. The sitting area was just outside the front door. The building had a circular driveway under an large awning going by the front door. The area had no			

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	fence around the front door or the facility grounds. The front door was facing a county road set back approximately 50 feet. There was no staff in the area, but the front doors were unlocked. During an interview with the DON on 7/15/2011 at 12:01 P.M., she indicated "Everybody (meaning the residents) here can go outside on their own." She indicated there were five doors in the building and all of them, except the front doors, had alarms on them. She indicated Residents A and B used the front door and went outside daily. She indicated the staff use one of the side doors and no one coming to work at 10 P.M. that night saw Residents A and B at the front door. During an interview with the Administrator on 7/15/2011 at 3:30 P.M., she indicated the residents are not checked on routinely unless it was on their service plan. She indicated Residents A and B did not have any behaviors so they were not checked on. She further indicated if the residents were to be checked on it would have to be a requested service as the residents are not checked on just because they are here. These checks were not in the routine services provided. During an interview with the DON on			

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	7/15/2011 at 4:00 P.M., she indicated there was nothing in Resident A and B's assessment to indicate if every two hour checks were needed or not needed. Review the Resident Rights provided by the Administrator on 7/15/11 at 3:30 P.M., indicated "9. The resident has the right to be free from ... neglect...." This state residential tag relates to complaint IN00093520.			
R0214	(a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interview, the facility failed to update the Service Plan of 2 cognitively impaired residents, who were independently ambulatory themselves, to reflect the residents were to be monitored every 2 hours from 10 P.M. until 6 A.M. for 2 residents in a sample of 3 who were to be monitored every 2 hours during the night (Residents A and B). Findings include:	R0214	R0214 WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Both Residents A & B service plan were updated in writing on 07/15/2011 by the Administrator. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION	08/05/2011

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	1. On 7/15/2011 at 11:00 A.M., the Administrator provided a copy of the incident report which was sent to the ISDH (Indiana State Department of Health) on 07/11/2011. The incident occurred on 07/10/2011 into 07/11/2011. The brief description of the incident indicated: "At 9PM on 07/10/11, (names of Residents A and B) walked out the front door to sit on the front porch glider. They were unaware of the front door being locked from the outside at 8PM. At 9:20PM (names of Residents A and B) attempted to come back into the building and discovered the front door was locked. (Names of Residents A and B) are independent with nursing services (dressing, ambulation, toileting, feeding etc) but do have dementia. They could not figure out how to use the after hours phone located by the front door nor could they process a solution for notifying someone that they were locked out. (Name of Resident A) brought the front porch glider into the foyer area (This is an area between two sets of front doors which is enclosed) and they slept on the porch glider until 4AM. At 4AM, (Resident A) walked to the side of the building and knocked on (Name of Resident)'s apartment window. (Name of Resident) then called the police stating		WILL BE TAKEN: The service plans for other residents identified as needing 2 hour checks for any reason, were reviewed to ensure that the 2 hour check intervention was listed on their service plan by the Administrator on 07/15/2011. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES THE FACILITY WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The Director of Nursing will be responsible for writing immediate updates on the service plan to ensure that the service plan is kept current at all times. The Director of Nursing will notify the resident and/or responsible party of the change in the service plan. The Administrator will review the service plans semi-annually and print off revisions made to the service plan at that time. HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE The Administrator will review the service plans weekly to verify that immediate updates on service plans are visible on the service plan. Findings from the weekly review will be discussed during the weekly Department Manager Meeting and then quarterly during the Quarterly Assurance Meeting. The monitoring will continue	

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	someone was trying to break into her apartment. The police called the facility and notified the staff of the call. The staff went to investigate and discovered that (Residents A and B) were in the foyer area at 4:13 AM. (Names of Residents A and B) were not injured. (Names of Residents A and B) then went to their apartment." The preventive measures taken were: ".... The (Name of Residents A and B) were placed on 2-hour checks from 10P-6A for whereabouts verification on 07/11/2011...." Resident A's clinical record was reviewed on 7/15/2011 at 10:55 A.M. Resident A's diagnoses included, but were not limited to, dementia. Resident A had a guardian. Resident A's Service Plan lacked every 2 hour checks from 10 P.M. until 6 A.M. Resident B's clinical record was reviewed on 7/15/2011 at 11:08 A.M. Resident B's diagnoses included, but were not limited to, dementia and confusion. Resident B had a guardian. Resident B's Service Plan lacked every 2 hour checks from 10 P.M. until 6 A.M. During an interview with the DON on		indefinitely as this is our policy.	

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	7/15/2011 at 4:00 P.M., she indicated there was nothing in Resident A and B's assessment to indicate if every 2 hour checks were needed or not needed. This state residential tag relates to complaint IN00093520.			
R0349	(a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to document in the clinical record the incident of 2 residents who had been locked out of the facility for 6 hours at night and then to document the assessment of the residents when they had re-entered the facility for 2 of 3 residents reviewed for clinical records in a sample of 3 (Residents A and B). Findings include: 1. On 7/15/11 at 11:00 A.M., the Administrator provided a copy of the incident report which was sent to the ISDH (Indiana State Department of Health) on 07/11/2011. The incident occurred on 07/10/2011 into 07/11/2011.	R0349	R0349 WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The nurses were inserviced on the Incident/Accident Policy on 08/02/2011. The inservice included discussion and definitions of incidents so that the nurses can identify what constitutes an incident. The Incident/Accident policy directs the nurse to complete an incident report which guides the nurse to perform specific tasks related to the incident which include an assessment, vitals, notification of family & physician. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE	08/05/2011

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	The brief description of the incident indicated: "At 9PM on 07/10/11, (names of Residents A and B) walked out the front door to sit on the front porch glider. They were unaware of the front door being locked from the outside at 8PM. At 9:20PM (names of Residents A and B) attempted to come back into the building and discovered the front door was locked. (Names of Residents A and B) are independent with nursing services (dressing, ambulation, toileting, feeding etc) but do have dementia. They could not figure out how to use the after hours phone located by the front door nor could they process a solution for notifying someone that they were locked out. (Name of Resident A) brought the front porch glider into the foyer area (This is an area between two sets of front doors which is enclosed) and they slept on the porch glider until 4AM. At 4AM, (Resident A) walked to the side of the building and knocked on (Name of Resident)'s apartment window. (Name of Resident) then called the police stating someone was trying to break into her apartment. The police called the facility and notified the staff of the call. The staff went to investigate and discovered that (Residents A and B) were in the foyer area at 4:13 AM. (Names of Residents A and B) were not injured. (Names of Residents		AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: The nurses were inserviced on the Incident/Accident Policy on 08/02/2011. The inservice included discussion and definitions of incidents so that the nurses can identify what constitutes an incident. The Incident/Accident policy directs the nurse to complete an incident report which guides the nurse to perform specific tasks related to the incident which include an assessment, vitals, notification of family & physician. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES THE FACILITY WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The nurses were inserviced on the Incident/Accident Policy on 08/02/2011. The inservice included discussion and definitions of incidents so that the nurses can identify what constitutes an incident. The Incident/Accident policy directs the nurse to complete an incident report which guides the nurse to perform specific tasks related to the incident which include an assessment, vitals, notification of family & physician. HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE WOODS	2335 NORTH MADISON AVENUE ANDERSON, IN46011

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	A and B) then went to their apartment." Resident A's clinical record was reviewed on 7/15/2011 at 10:55 A.M. Resident A's diagnoses included, but were not limited to, dementia. Resident A's nurse's notes lacked any notation of this incident or an assessment after the incident. Resident B's clinical record was reviewed on 7/15/2011 at 11:08 A.M. Resident B's diagnoses included, but were not limited to, dementia and confusion. Resident B's nurse's notes lacked any notation of this incident or an assessment after the incident. During an interview with the DON on 7/15/2011 at 12:01 P.M., she indicated the staff who were on duty that night were supposed to chart what had happened. This state residential tag refers to complaint IN00093520.		QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE The Director of Nursing, or designee will review the 24-report sheets daily to ensure that all incidents are processed according to the Incident/Accident Policy. The Director of Nursing, or designee will review the resident's medical chart following the submission of an Incident Report Form to ensure that the appropriate documentation was completed in that medical chart. The Director of Nursing will make a notation on the Incident Report Form once the review is completed. The findings of the review will be reviewed monthly during the Safety Committee Meeting and then Quarterly during the Quality Assurance Meeting. The monitoring for this will continue indefinitely as this is our policy.	